Stony Brook Medicine

NEUROPSYCHOLOGY SERVICE
PARENT QUESTIONNAIRE

Today's Date (Mo/Day/Yr) _____/_____/_____

Child's Name (First/Last) _____

Birth Date (Mo/Day/Yr): _____/_____/_____ Age: _____ Gender: Female_____ Male _____

Your Name (First/Last): _____ Your relationship to the child: _____

Your email address: _____

Who referred you to us? _____

Has your child previously been seen at Stony Brook University Hospital? No: _____ Yes _____

If yes, approximately when was your child seen? _____

Who saw your child at that time? (If you don't recall who, which Department) _____

OTHER CARE PROVIDERS:

Primary Physician Name: _____ Telephone #: _____

Psychiatrist Name: _____ Telephone #: _____

Psychotherapist Name: _____ Telephone #: _____

Other Care Providers (neurologist, speech therapist, etc.):

Name: _____ Telephone #: _____

Name: _____ Telephone #: _____

Name: _____ Telephone #: _____

CHILD'S HOME ADDRESS AND TELEPHONE (Please include Zip code)

_____
Address

_____
City, State, Zip code

_____
Home Telephone

_____

Cell Phone

Please read the following questions carefully and answer each one as thoroughly as possible. NOT all questions will apply to your child. When this is the case, please indicate so by writing N/A by the question.

CURRENT CONCERNS:

What are the main problems you are concerned about, and how long have they been present?

Problem	Present since (age)

DEVELOPMENTAL HISTORY: ***(If you don't know, please write DK)***

1. How many pregnancies did mother have before the birth of this child? (include those not carried to term) _____

2. Check **ANY** of the following that occurred during the pregnancy with this child:

_____ No complication

_____ Severe Nausea and Vomiting _____ Toxemia _____ Heart Disease

_____ High Blood Pressure _____ Rubella, Mumps _____ Injury/Accident

_____ Incompatible Rh Factor _____ Gestational Diabetes _____ Hospitalization

_____ Kidney Disease _____ Anemia _____ Seizures

_____ Bleeding: _____ 1st 3 mos. _____ 2nd 3 mos. _____ 3rd 3 mos.

3. Were any medications taken during pregnancy? _____ NO (1) _____ (YES (2)

If YES, please specify: _____

_____

4. Did the mother smoke or take drugs during the pregnancy? _____ (NO (1) _____ (YES) (2)

If YES, specify what, how much, and when: _____

_____

5. Did the mother consume alcohol during the pregnancy? _____(NO (1) _____ (YES (2)

If YES, specify how much and when: _____ _____

_____

6. Delivery Information:

Type of delivery (Check one): _____ Normal _____ C-Section _____ Breech _____ (Forceps

Was labor induced? _____ NO (1) _____ YES (2)

Did ANY of the following occur at or following the delivery of the child:

_____ No problems with delivery, or following delivery

_____ Premature delivery: How many days before due date? _____

_____ Late delivery: How many days past due date? _____

_____ Infant had cord around neck

_____ Infant was blue at birth

_____ Infant was jaundiced: How treated? _____

_____ Infant required oxygen: For how long? _____

_____ Infant required blood transfusion: For what reason?_____

_____ Infant was placed in an incubator: For how long? _____

_____ Other problems (please specify): _____)

7. Child's weight at birth: _____ pounds _____ ounces

APGAR Scores: _____ 1 minute _____ 5 minutes

Length of hospital stay: _____ Was this longer than the Mother's stay? _____ NO _____ YES

8. If YES, provide the reason. _____

_____

9. As an infant, how would you have described your child? (Check **ALL** that apply)

_____ Slept too much _____ Unresponsive to parents/familiar adults

_____ Rarely seemed to sleep _____ Seemed "too good"

_____ Fussed excessively _____ Colicky

_____ Feeding difficulties _____ Overly active

_____ Resisted being held _____ Excessively clingy

_____ No reaction to separation _____ No or unusual reaction to strangers

DEVELOPMENTAL MILESTONES ***(if you don't know, please write DK)***

Please provide the age at which your child accomplished the following milestones:

Milestone	Age in months or years	Milestone	Age in months or years
Rolled over		Ate with utensils	
Sat unsupported		Cut with scissors	
Crawled		Toilet trained during day (bladder)	
Walked independently		Toilet trained at night (bladder)	
Rode a tricycle		Toilet trained during day (bowel)	
Rode a bicycle		Toilet trained at night (bowel)	
Gestures(bye-bye,etc)			
Babbling			
Spoke single words			
Spoke in phrases (2-3 words)			
Spoke in sentences (4+ words)			

Has your child established handedness yet? _____ NO (1) _____ YES (2) If YES, which hand _____ Right (1) _____ Left (2)

Prior to the development of speech, did your child? (**PLEASE CHECK ALL THAT APPLY**)

_____ use physical gestures to gain parent's attention
_____ pull parents to desired objects
_____ try to share interests with others (such as offering parents food or interesting toys)
_____ point to desired objects
_____ wave bye-bye or hello without prompting
_____ use parent's hands as a tool, such as placing parent's hand on door to indicate the child wanted to leave?

MEDICAL HISTORY

1. Please check **ALL** that apply to the child:

_____ Birth Abnormalities
_____ Heart Disease
_____ Anemia
_____ Physical handicaps
(describe:_____)
_____ Asthma
_____ Allergies
(describe:_____)
_____ Food sensitivities
_____ Lead poisoning
_____ Other poisoning
(describe:_____)
_____ Chicken Pox
_____ Problems with vision
_____ Problems with hearing
_____ Epilepsy/seizures/convulsions
_____ Seizures with high temperature
_____ Fever over 104 with unknown cause
_____ Emergency Room visit
(describe: _____)
_____ Head Injury
_____ Head Injury with loss of consciousness
_____ Loss of consciousness other than above
_____ Serious accident
_____ Meningitis
_____ Recurrent ear infections
_____ Encephalitis
_____ Mumps
_____ Other serious childhood disease
(describe: _____)

3. Has your child ever been hospitalized for a medical problem? _____ NO (1) _____ YES (2)
If YES, reason: _____
When? _____ Where? _____

PSYCHIATRIC HISTORY

1. Has your child ever been hospitalized for a behavioral or psychiatric problem? _____ NO (1) _____ YES (2)
   If YES, reason: _____
   When? _____ Where? _____

2. Has your child received mental health treatment (e.g., counseling, therapy, psychiatrist)? _____ NO(1)_____ YES (2)
   If YES, reason: _____
   Are they still in treatment? _____ NO (1) _____ YES (2) Provider Name:_____
   If YES, frequency of treatment: _____

PRIOR TESTS

Has your child received a medical work-up. Such as:

EEG's _____ NO (1) _____ YES (2)
If YES, please provide reason/results: _____

Fragile X _____ NO (1) _____ YES (2)
If YES, please provide reason/results: _____

MRI _____ NO (1) _____ YES (2)
If YES, please provide reason/results: _____

OTHER TESTS (hearing, metabolic, endocrine, etc.):

_____ please provide reason/results: _____

_____ please provide reason/results: _____

IMMUNIZATIONS

Are your child's immunizations appropriate for his age? _____ NO (1) _____ (YES (2)
If not, please mention which are not current:

ALLERGIES

Please list any medication allergies your child has:

Name of medication _____ Allergic Reaction _____
Name of medication _____ Allergic Reaction _____
Name of medication _____ Allergic Reaction _____
Other allergies:

PREVIOUS EVALUATIONS

1. Has your child ever received a diagnostic evaluation before? _____ NO (1) _____ YES (2)
   Is YES, please specify (if more than one evaluation, please put additional information at bottom of page):
   Where and when was child seen? _____
   By whom? _____
   What diagnosis was given? _____
   If possible, please enclose a copy of the report(s) with this questionnaire.
   Additional comments: _____
   _____

MEDICATION HISTORY

1. Has your child every been treated with medication for his/her problems? _____ NO (1) _____ YES (2)

   If YES, list each medication, dosage, and age of child:

   Name/dose of Medication: _____ (age _____ to _____)
   Name/dose of Medication: _____ (age _____ to _____)
   Name/dose of Medication: _____ (age _____ to _____)
   Name/dose of Medication: _____ (age _____ to _____)
   Name/dose of Medication: _____ (age _____ to _____)
   Name/dose of Medication: _____ (age _____ to _____)

2. Is your child taking medication at the present time? _____ NO (1) _____YES (2)

   Name/dose of Medication: _____ (age _____ to _____)
   Name/dose of Medication: _____ (age _____ to _____)
   Name/dose of Medication: _____ (age _____ to _____)
   Name/dose of Medication: _____ (age _____ to _____)
   Name/dose of Medication: _____ (age _____ to _____)
   Name/dose of Medication: _____ (age _____ to _____)

SCHOOL INFORMATION

CURRENT EDUCATIONAL PLACEMENT:

1. What school district do you live in? _____
2. What school does your child currently attend? _____

   Address:

   _____

   _____

   Telephone #: ( ) _____ Teacher: _____
3. Current grade (if summer, give grade starting in September): _____
4. Has your child been evaluated by the CSE or CPSE: _____ NO (1) _____ YES (2)
5. Does your child have a Special Education Classification? (e.g., Autism, Speech/Language Impaired, OHI)

   _____ NO (1) _____ YES (2) (If YES, please specify: _____)
6. Is your child currently receiving Special Education Services?_____NO (1) _____ YES (2)
7. What sort of classroom does your child attend?

   _____ Regular Education (0)
   _____ Inclusion Classroom (1)
   _____ Regular Education with Resource Room (what subjects?) (2) _____
   _____ Special Education Classroom in Home District (3)

   What is the student/teacher ratio? (e.g., 12:1:1) _____

   Is your child mainstreamed for any subjects? _____

   _____ Special Education Classroom in Special Education School (includes Preschool Programs (4)

   What is the student/teacher ratio? (e.g., 12:1:1) _____

   _____ Residential or Hospital Setting (5)
8. What supportive services does your child receive (e.g., speech therapy, OT, PT, counseling)?

   a) _____ How many times per week? _____
   b) _____ How many times per week? _____
   c) _____ How many times per week? _____

9. What, if any, are your current concerns regarding your child's educational programming?

D. EDUCATIONAL HISTORY

For each grade in school, please check all of the following that apply. If your child does not yet attend school, please skip this section and go to the next.

School Year	Type of School (✓ one)		Type of Class (✓ one)		Special Services (Please check all that apply)		
	Regular	Special	Regular	Special	Service	Type	Session Length/ Frequency
Early Intervention services ages (birth – 3 years) Name of school:	NOT APPLICABLE				☐ SPEECH & LANGUAGE THERAPY	☐ INDIVIDUAL ☐ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					☐ PHYSICAL THERAPY	☐ INDIVIDUAL ☐ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					☐ OCCUPATIONAL THERAPY	☐ INDIVIDUAL ☐ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					☐ COUNSELING	☐ INDIVIDUAL ☐ SMALL GROUP	___MINUTES ___ TIMES/WEEK
Pre-School Services Ages (3 yrs – 5 yrs) Name of school:					☐ SPEECH & LANGUAGE THERAPY	☐ INDIVIDUAL ☐ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					☐ PHYSICAL THERAPY	☐ INDIVIDUAL ☐ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					☐ OCCUPATIONAL THERAPY	☐ INDIVIDUAL ☐ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					☐ COUNSELING	☐ INDIVIDUAL ☐ SMALL GROUP	___MINUTES ___ TIMES/WEEK
Kindergarten Name of School:					☐ SPEECH & LANGUAGE THERAPY	☐ INDIVIDUAL ☐ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					☐ PHYSICAL THERAPY	☐ INDIVIDUAL ☐ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					☐ OCCUPATIONAL THERAPY	☐ INDIVIDUAL ☐ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					☐ COUNSELING	☐ INDIVIDUAL ☐ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					☐ RESOURCE ROOM	☐ INDIVIDUAL ☐ SMALL GROUP	___MINUTES ___ TIMES/WEEK
1st Grade Name of School:					☐ SPEECH & LANGUAGE THERAPY	☐ INDIVIDUAL ☐ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					☐ PHYSICAL THERAPY	☐ INDIVIDUAL ☐ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					☐ OCCUPATIONAL THERAPY	☐ INDIVIDUAL ☐ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					☐ COUNSELING	☐ INDIVIDUAL ☐ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					☐ RESOURCE ROOM	☐ INDIVIDUAL ☐ SMALL GROUP	___MINUTES ___ TIMES/WEEK

School Year	Type of School (✓ one)		Type of Class (✓ one)		Special Services (Please check all that apply)		
	Regular	Special	Regular	Special	Service	Type	Session Length/ Frequency
2nd Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
3rd Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
4th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
5th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
6th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK

School Year	Type of School (✓ one)		Type of Class (✓ one)		Special Services (Please check all that apply)		
	Regular	Special	Regular	Special	Service	Type	Session Length/ Frequency
7th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
8th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
9th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
10th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
11th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK

School Year	Type of School (✓ one)		Type of Class (✓ one)		Special Services (Please check all that apply)		
	Regular	Special	Regular	Special	Service	Type	Session Length/ Frequency
12th Grade Name of School:					□ SPEECH & LANGUAGE THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ PHYSICAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ OCCUPATIONAL THERAPY	□ INDIVIDUAL □ SMALL GROUP	___ MINUTES ___ TIMES/WEEK
					□ COUNSELING	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK
					□ RESOURCE ROOM	□ INDIVIDUAL □ SMALL GROUP	___MINUTES ___ TIMES/WEEK

BACKGROUND INFORMATION ON YOUR CHILD:

1. Race / Ethnicity:
   1. _____ White
   2. _____ Black
   3. _____ Hispanic
   4. _____ Asian
   5. _____ Other, please specify: _____

2. With whom does the child currently live? (Check **ALL** that apply)

_____ biological mother
_____ biological father
_____ adoptive mother
_____ adoptive father
_____ step-parent or parent's partner
_____ other (who? _____)
_____ foster mother
_____ foster father
_____ siblings (how many? _____)
_____ other relatives
_____ other non-relatives

3. Marital Status of BIOLOGICAL PARENTS: (Check **ALL** that apply)

_____ married
_____ living together
_____ never married
_____ separated
_____ divorced
_____ mother remarried
_____ father remarried
_____ mother deceased
_____ father deceased

4. List **ALL** children (including patient) in order of birth. *(Please include last name, if different from referred child's)*

NAME	DOB	GRADE	Lives at home? Y/N	Same biological Mother? Y/N	Same biological Father? Y/N	Any developmental delays? If yes, indicate type of delays Y/N
_____	___ ___ ___	_____	___	___	___	_____
_____	___ ___ ___	_____	___	___	___	_____
_____	___ ___ ___	_____	___	___	___	_____
_____	___ ___ ___	_____	___	___	___	_____

PARENT/CAREGIVER INFORMATION

NOTE: If you don't know the answer to any of these questions, please indicate this by entering "DK"

1. Mother's Name (First/Last): _____

Date of Birth (Mo/Day/Yr): ___ ___ ___ Telephone #: (_____) _____

Address (if different from child's):

Present Occupation: _____ Employed: Full Time / Part Time

Name of Employer: _____

Telephone # at work: (_____) _____

Ethnicity:

1. _____ White
2. _____ Black
3. _____ Hispanic
4. _____ Asian
5. _____ Other, please specify: _____

1. Father's Name (First/Last): _____

Date of Birth (Mo/Day/Yr): ___ ___ ___ Telephone #: (_____) _____

Address (if different from child's):

Present Occupation: _____ Employed: Full Time / Part Time

Name of Employer: _____

Telephone # at work: (_____) _____

Ethnicity:

1. _____ White
2. _____ Black
3. _____ Hispanic
4. _____ Asian
5. _____ Other, please specify: _____

3. Highest level of education:

	Mother	Father
1. 8th grade or less	_____	_____
2. some high school	_____	_____
3. high school graduate	_____	_____
4. some college	_____	_____
5. associate degree	_____	_____
6. bachelor's degree	_____	_____
7. master's degree	_____	_____
8. doctoral degree	_____	_____

4. Family Income: (Please check one)

1. Less than $10,000/year _____
2. $10,000 – 20,000/year _____
3. $20,001 – 40,000/year _____
4. $40,001 – 70,000/year _____
5. $70,001 – 100,000/year _____
6. $100,001 or more/year _____

FAMILY HISTORY

To your knowledge, have your or any members of the child's family (that is, parents, other children, aunts, uncles, or grandparents on either side) ever had any of the following problems? Is so, *please specify the person's relationship to the child, e.g., aunt, uncle) and whether the individual was on the mother's or father's side of the family.*

	Relationship to Child	Mother's Side	Father's Side
Autism spectrum disorder			
Specify if known:			
Autism			
Asperger's disorder			
PDD-NOS			
Intellectually Disabled			
Learning disabilities			
Hyperactivity (Attention			
Deficit Disorder) Bipolar			
(manic depressive)			
Alcoholism			
Nervous Breakdown			
Epilepsy			
Drug Abuse			
Depression			
Severe mood swings			
Psychiatric hospitalization			
Committed a serious			
crime Schizophrenia			
Severe anxiety			
Other (describe)			

SLEEP AND SCREENS

Does your child currently have any sleep difficulties? ☐ Yes ☐ No
If yes, please describe _____

Does your child experience any of the following (check all that apply):
☐ Difficulty falling asleep ☐ Bedwetting
☐ Difficulty staying asleep ☐ Nightmares
☐ Waking too early

Does your child need medication to sleep? ☐ Yes ☐ No
If yes, what kind? _____

Does your child use technology right before bed? ☐ Yes ☐ No

Are any of the following in your child's room? ☐ TV ☐ Phone ☐ iPad ☐ Video Games ☐ Other

Time per day your child spends on technology? _____ hours

Times of the day your child is on your technology? ☐ Morning ☐ After School ☐ Evening ☐ Before Bed

Do you keep track of your child's internet activity? ☐ Yes ☐ No

What websites does your child most frequently visit? _____

Did (does) your child have any of the following difficulties with the development of speech and language skills?
(**PLEASE CHECK ALL THAT APPLY**)

SKILL	IN THE PAST	AT PRESENT
___ NO DIFFICULTIES	□	□
___ NON-VERBAL	□	□
___ BABBLES WITHOUT INTENT TO COMMUNICATE	□	□
___ DELAY IN SPEECH DEVELOPMENT	□	□
___ REPEATS WORDS/PHRASES OUT OF CONTEXT	□	□
___ ECHOLALIA (REPEATS PHRASES OR REPEATS QUESTIONS RATHER THAN ANSWER THEM)	□	□
___ SEEMS TO HAVE A MADE-UP LANGUAGE OR USES MADE UP WORDS	□	□
___ PRONOUN REVERSAL ("YOU" INSTEAD OF "I", ETC.)	□	□
___ MONOTONE, ODD PITCH, OR "SING SONG" VOICE	□	□
___ EXCESSIVE STAMMERING/STUTTERING	□	□
___ CAN'T STOP TALKING ABOUT CERTAIN TOPICS (PERSEVERATES)	□	□
___ SPEAKS AS IF LECTURING OTHERS	□	□
___ PRAGMATIC DIFFICULTIES (POOR EYE CONTACT, CAN'T MAINTAIN SOCIAL CONVERSATION)	□	□
___ DOESN'T USE FACIAL EXPRESSIONS THAT COMMUNICATE GUILT, SURPRISE, SADNESS, ETC.	□	□

SOCIAL FUNCTIONING

1. Did your child show an interest in playing "nursery games" such as peek-a-boo or patty cake? _____ NO (1) _____ YES (2)
2. Is your child interested in toys? _____ NO (1) _____ YES (2)
   IF YES, please indicate the child's favorite toys: _____
3. Was your child fascinated with lights, spinning objects, or parts of toys, such as caps, wheels, etc.?
4. Has your child developed symbolic (letting a common household item stand in for another item) make believe or pretend play skills? _____ NO (1) _____ YES (2)
   If YES, please provide examples:
5. Does (did) your child have any repetitive play skills (That is, does your child pay the same game or make believe story over and over, play with only one or two toys, etc.) _____ NO (1) _____ YES (2)
6. Is your child interested in other children's play? _____ NO (1) _____ YES (2)
7. Does your child have a best friend? _____ NO (1) _____ YES (2)
8. Does your child have any friends? _____ NO (1) _____ YES (2)
9. Would you describe your child as wanting friends, but lacking knowledge about how to make friends? _____ NO (1) _____ YES (2)
10. Does (did) your child imitate the behaviors of others? _____ NO (1) _____ YES (2)
11. Does (did) your child seem preoccupied with letters,numbers,maps,dialogue from movies, TV, videos, etc? _____ NO (1) _____ YES (2)
12. Does (did) your child have difficulty relating to peers? _____ NO (1) _____ YES (2)
13. Does your child try to dominate play with others? _____ NO (1) _____ YES (2)
14. Does (did) your child make inappropriate social gestures,such as biting,hitting,etc. to approach others? _____ NO (1) _____ YES (2)

BEHAVIORAL FUNCTIONING

Please check **ALL** of these items that apply to your child. Please provide an explanation of the behavior in the space provided.

BEHAVIOR	EXPLANATION OF BEHAVIOR
___ No behavior problems	_____
___ Excessive tantrums	_____
___ Upset by change	_____
___ Difficulty with transitions	_____
___ Becomes too interested in topics/items	_____
___ Unaware of body in space/clumsy	_____
___ Self-stimulatory behaviors (spins toys, flaps arms, waves toys in front of face, etc.)	_____
___ Self-abusive behaviors	_____
___ Routine-oriented (gets upset if daily routine changes)	_____
___ Overly rigid or demanding	_____
___ Ritualistic Behavior (repeats certain stereotypic behaviors over and over)	_____
___ Unusual interests (washing machines, vacuums, people's birthdays, etc)	_____
___ Repetitive play/actions	_____
___ Interested in smelling objects	_____
___ Interested in feeling/touching objects	_____
___ Mouths toys (puts toys in mouth)	_____
___ Withdraws from affection	_____
___ No reaction/over-reaction to pain	_____
___ Over-sensitive to sounds/lights	_____
___ Aggressive toward others	_____
___ Impulsive	_____
___ Overactive	_____
___ Poor attention span	_____
___ Seems emotionally distant	_____
___ Takes a person's hand/arm to get a desired object	_____
___ Seems to look through people as if they weren't there	_____
___ Very disorganized	_____
___ Sleeping problems	_____
___ Has a special skill	_____

GENERAL LOSS OF SKILLS

Was there a period during which your child seemed to lose skills that s/he acquired earlier, other than during a physical illness?

_____ NO (1) _____ YES (2)

IF SO, PLEASE COMPLETE THE FOLLOWING CHART:

SKILL	APPROXIMATE AGE OF LOSS OF SKILL	WAS LOSS OF SKILL ASSOCIATED WITH A PHYSICAL ILLNESS?
_____ COMMUNICATION		_____ NO (1) _____ YES (2)
_____ SOCIAL INTERACTION & RESPONSIVENESS		_____ NO (1) _____ YES (2)
_____ PLAY AND IMAGINATION		_____ NO (1) _____ YES (2)
_____ SELF CARE SKILLS (GROOMING, EATING, ETC.		_____ NO (1) _____ YES (2)
_____ ACADEMIC OR VOCATIONAL SKILLS		_____ NO (1) _____ YES (2)
_____ MOTOR SKILLS (COORDINATION)		_____ NO (1) _____ YES (2)
_____ TOILET TRAINING (BLADDER)		_____ NO (1) _____ YES (2)
_____ TOILET TRAINING (BOWEL)		_____ NO (1) _____ YES (2)

PLEASE USE THIS PAGE FOR ANY ADDITIONAL INFORMATION YOU MAY FEEL IT'S IMPORTANT FOR US TO KNOW ABOUT YOUR CHILD

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